MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06542

CERTIFICATE OF DEATH

06527

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural, North East
c. LENGTH OF STAY IN 1b: 1 yr. 8mos.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Calvert Manor Nursing Home

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural, North East
d. STREET ADDRESS: R.D. 1
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First LUTHER Middle B. Last AKERS

4. DATE OF DEATH: Month May Day 29 Year 19 67

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]

8. DATE OF BIRTH: June 20, 1884

9. AGE (In years last birthday): 82 yrs.

IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Farming

11. BIRTHPLACE (County & State, or foreign country): Mercer Co. W. Va.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: James F. Akers

14. MOTHER'S MAIDEN NAME: Polly E. McCommas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): NO

16. SOCIAL SECURITY NO.: 217-36-3704

17. INFORMANT: Vernon A. Akers — Address: R.D. 1 Box 78, North East, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 3 days
DUE TO (b): Bleeding Gastric Ulcer — 10 days
DUE TO (c): Arteriosclerotic Heart Disease — 17 yrs.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Parkinsonism

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER): —

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): —

20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19 —

20d. INJURY OCCURRED While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): —

20f. (City or town) — (County) — (State) —

21. I **certify** that (I) (this hospital) attended the deceased from June, 1950, to 24 May, 1967, that (I) (we) last saw the deceased alive on 28 May 1967, and that death occurred at 12:50 P.M., from causes and on the date stated above.

22a. SIGNATURE: Klaus H. Huebner — M.D. ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]

22b. DATE SIGNED: 5/29/67

22c. PHYSICIAN'S NAME (Type): KLAUS H. HUEBNER

22d. ADDRESS: NORTH EAST, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 6/1/67

23c. NAME OF CEMETERY OR CREMATORY: Friends Burying Grounds

23d. LOCATION (City or Town) (County) (State): Cecil Md.

24. FUNERAL DIRECTOR: Grant Funeral Home — ADDRESS: Box 22, North East, Md.

25a. REC'D BY REGISTRAR DATE: JUN 1 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 7/66

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06543 — 06528

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural North East
c. LENGTH OF STAY IN 1b: 29 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): R.D. 1

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural North East
d. STREET ADDRESS: R.D. 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First AGNES — Middle B. — Last BENJAMIN

4. DATE OF DEATH: Month May — Day 18 — Year 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Feb. 17, 1907

9. AGE (In years last birthday): 60 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (County & State, or foreign country): Fancy Gap, Va.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Jacob C. Bailiff

14. MOTHER'S MAIDEN NAME: Mary E. Smith

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: Otis B. Benjamin — Address: R.D. 1, North East, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Brain tumor : Glioblastoma multiforme — INTERVAL BETWEEN ONSET AND DEATH: 10 months
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 21 Sept, 1966, to 18 May, 1967, that (I) (we) last saw the deceased alive on 17 May 1967, and that death occurred at 9 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Klaus H. Huebner — M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 5/18/67

22c. PHYSICIAN'S NAME (Type): KLAUS H. HUEBNER

22d. ADDRESS: NORTH EAST, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 5/21/67

23c. NAME OF CEMETERY OR CREMATORY: Bay View Methodist

23d. LOCATION (City, town or county) (State): Cecil County Md.

24. FUNERAL DIRECTOR: Grant Funeral Home — Paul R Crouch — ADDRESS: Box 22 North East, Md.

25a. REC'D BY REGISTRAR DATE: MAY 29 1967

25b. REGISTRAR'S SIGNATURE: J Charles Judge

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06544 — 06529

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rising Sun, Rural
c. LENGTH OF STAY IN 1b: Years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): R. F. D. # 1

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rising Sun, Rural
d. STREET ADDRESS: R. F. D. # 1
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Charlotte — Middle: Arminta — Last: Boyd
4. DATE OF DEATH: Month: May — Day: 21 — Year: 67
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]
8. DATE OF BIRTH: 5--28--1879
9. AGE (In years last birthday): 87 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife Ret.
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (County & State, or foreign country): Raven Virginia
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Henry W. Van Dyke
14. MOTHER'S MAIDEN NAME: Lucinda Webb

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dotes of service): No
16. SOCIAL SECURITY NO.: 220-46-8647
17. INFORMANT — Address: Isaec Boyd Rising Sun, Md. (Son)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): = Carcinoma of Stomach
DUE TO (b): = Hepato megaly...
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.
DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH: 6 mo.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Arteriosclerotic Cardiovascular Disease
19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work [ ] Not While at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Dec., 1966 to May, 1967 that (I) (we) last saw the deceased alive on May 19 1967, and that death occurred at 5:30 AM from causes and on the date stated above.

22a. SIGNATURE: Ernest W. Seiter M.D. — ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]
22b. DATE SIGNED: May 22, 1967
22c. PHYSICIAN'S NAME (Type): Ernest W, Seiter M. D.
22d. ADDRESS: 28 Cherry St. Rising Sun, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 5-24-1967
23c. NAME OF CEMETERY OR CREMATORY: Hopewell Cem.
23d. LOCATION (City or Town) (County) (State): Port Deposit Cecil Md.
24. FUNERAL DIRECTOR: E. M. Mullen Dir. — ADDRESS: Tyson Funeral Home Rising Sun, Md.
25a. REC'D BY REGISTRAR: MAY 23 1967 DATE
25b. REGISTRAR'S SIGNATURE: Jeanne Jorge

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06545 **CERTIFICATE OF DEATH** 06530

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point
c. LENGTH OF STAY IN 1b: 3 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): VA Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Penna.
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Philadelphia
d. STREET ADDRESS: 3352 Disston St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Charles — Middle: C. — Last: BRADFORD
4. DATE OF DEATH: Month: May — Day: 13 — Year: 19 67
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 11-23-87
9. AGE (In years last birthday): 79 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Watchman
10b. KIND OF BUSINESS OR INDUSTRY: -
11. BIRTHPLACE (County & State, or foreign country): Philadelphia, Pa.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.
13. FATHER'S NAME: Charles C. Bradford (Deceased)
14. MOTHER'S MAIDEN NAME: Mary Collins (Deceased)
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes give war or dates of service): WWI
16. SOCIAL SECURITY NO.: 169-12-36-40
17. INFORMANT — Address: VA Hospital Records - Perry Point, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Asphyxia due to aspiration of Gastric Contant AND	10 Min.
XXXX	Broncho Pneumonia of both lower lobes	5-10 days
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. XX DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. p.m.
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 5-10-67, 19__ to 5-13-67, 19__ XXXXXXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX, and that death occurred at 5:50 p.m. M, from causes and on the date stated above.

22a. SIGNATURE: Ben Rothfeld M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 5 14 67
22c. PHYSICIAN'S NAME (Type): BENJ. ROTHFELD, M.D.
22d. ADDRESS: VA Hospital - Perry Point, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal / Burial
23b. DATE THEREOF: May 14, 1967
23c. NAME OF CEMETERY OR CREMATORY: Holy Redeemer Cemetery
23d. LOCATION (City or Town) (County) (State): Philadelphia, Penna.

24. FUNERAL DIRECTOR: JOHN J. MC FARLAND FUNERAL HOME — Lee R. Walton & Son, Perryville, Md. — ADDRESS: 989 Pratt St., Philadelphia Pa.
25a. REC'D BY REGISTRAR DATE: MAY 19 1967
25b. REGISTRAR'S SIGNATURE: J Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06546 — 06531

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point
c. LENGTH OF STAY IN 1b: 10 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): Veterans Administration Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: District of Columbia — b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 200 Trenton Place, SE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First CLARENCE — Middle F. — Lost BURR
4. DATE OF DEATH: Month May — Day 12 — Year 19 67
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 7-5-84
9. AGE (In years last birthday): 82 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Office worker
10b. KIND OF BUSINESS OR INDUSTRY: ——
11. BIRTHPLACE (County & State, or foreign country): Cream Ridge, New Jersey
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Burr (D)
14. MOTHER'S MAIDEN NAME: Eleanor Atkinson (D)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): Yes — WW I
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT Address: VA Hospital Records, Perry Point, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic heart disease — INTERVAL BETWEEN ONSET AND DEATH: 6-12 mos.
(b): and Carcinoma of right lung
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that ☒ (this hospital) attended the deceased from May 2, 1967, to May 12, 1967 [illegible] and that death occurred at 8:50 am, from causes and on the date stated above.

22a. SIGNATURE: Joaquin R. Garcia M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS ☒
22b. DATE SIGNED: 5-12-67
22c. PHYSICIAN'S NAME (Type): J. R. GARCIA, M.D.
22d. ADDRESS: VA Hospital, Perry Point, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: May 15, 1967
23c. NAME OF CEMETERY OR CREMATORY: Long Island National Cem.
23d. LOCATION (City or Town) (County) (State): Pinelawn, Long Island, N.Y.
24. FUNERAL DIRECTOR: Lee A Patterson & Son Funeral Home, Perryville, Maryland
ADDRESS
25a. RECD BY REGISTRAR: MAY 19 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06547 — 06532

1. PLACE OF DEATH
- a. COUNTY: Cecil, MARYLAND
- b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Port Deposit - Rural
- c. LENGTH OF STAY IN 1b: Life
- d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Craigtown Road

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
- a. STATE: Maryland
- b. COUNTY: Cecil
- c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Port Deposit - Rural
- d. STREET ADDRESS: Craigtown Road
- e. IS RESIDENCE ON A FARM? YES [x] NO [ ]

3. NAME OF DECEASED (Type or print): First: Elizabeth — Middle: Viola — Last: Campbell

4. DATE OF DEATH: Month: May — Day: 25, — Year: 19 67

5. SEX: Female

6. COLOR OR RACE: Cau

7. MARRIED [ ] NEVER MARRIED [x] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: Jan. 6, 1892

9. AGE (In years last birthday): 75 yrs — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Charles S. Campbell

14. MOTHER'S MAIDEN NAME: Martha H. Donahoo

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes give war or dates of service): ---

16. SOCIAL SECURITY NO.: unknown

17. INFORMANT — Address: Robert J. Campbell, Port Deposit, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)

PART I. DEATH WAS CAUSED BY		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Cerebral Hemorrhage	8 [illegible]
DUE TO (b)	Cerebral Sclerosis -	16 mths
DUE TO (c)	Arterio Sclerosis -	3 yrs

351X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Cerebral Accident, Paralysis left side, [illegible] - Jan 19-66 -

19. WAS AUTOPSY PERFORMED? YES [ ] NO [x]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19

20d. INJURY OCCURRED While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Jan. 19, 19 66, to May 25, 19 67, that (I) (we) last saw the deceased alive on May 25 19 67, and that death occurred at 11:2 [illegible] M, from causes and on the date stated above.

22a. SIGNATURE: Clarence I. Benson M.D. — ATTENDING PHYS. [x] MED. DIRECTOR [ ] STAFF PHYS. [ ]

22b. DATE SIGNED: May-26-1967

22c. PHYSICIAN'S NAME (Type): Clarence I. Benson M.D.

22d. ADDRESS: Port Deposit, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: May 29, 1967

23c. NAME OF CEMETERY OR CREMATORY: Asbury Cemetery

23d. LOCATION (City or Town) (County) (State): Port Deposit, Md.

24. FUNERAL DIRECTOR — ADDRESS: Lee A. Patterson & Son, Perryville, Md.

25a. REC'D BY REGISTRAR — DATE: [illegible]

25b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (5)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

3C548 — 06533

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH — a. COUNTY: CECIL — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ELKTON
   c. LENGTH OF STAY IN 1b: LIFE
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 105 DEL. AVE.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) — a. STATE: MD — b. COUNTY: CECIL
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ELKTON
   d. STREET ADDRESS: 105 DEL. AVE — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First THOMAS — Middle M. — Last CARR

4. DATE OF DEATH: Month 5 — Day 2 — Year 1967

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 9-11-1894

9. AGE (In years last birthday): 72 yrs. — IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RET GOVT. WORKER

10b. KIND OF BUSINESS OR INDUSTRY: U.S. GOVT.

11. BIRTHPLACE (County & State, or foreign country): STANTON, DEL

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: HARRY CARR

14. MOTHER'S MAIDEN NAME: SARAH MANN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): YES — (If yes give war or dates of service): WWI

16. SOCIAL SECURITY NO.: 169-20-1491

17. INFORMANT — Address: MOLLIE A. CARR — ELKTON, MD

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic Brain Disease — INTERVAL BETWEEN ONSET AND DEATH: 1 year
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from July 16, 1966, to May 2, 1967, that (I) (we) last saw the deceased alive on May 2 1967, and that death occurred at 2¾ P.M., from the causes and on the date stated above.

22a. SIGNATURE: [signature] — M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: 5/7/67

22c. PHYSICIAN'S NAME (Type): Ray V. Davis M.D. — 22d. ADDRESS: Elkton Md

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL — 23b. DATE THEREOF: 5-6-67 — 23c. NAME OF CEMETERY OR CREMATORY: GILPIN MANOR MEM. PK. — 23d. LOCATION (City, town or county) (State): ELKTON, MD

24. FUNERAL DIRECTOR — ADDRESS: Robert Edward Gilpin Funeral Home, Elkton, Md

25a. REC'D BY REGISTRAR — DATE: MAY 5 1967 — 25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE HEALTH DEPT.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06543 06534

1 PLACE OF DEATH
a COUNTY: Cecil — MARYLAND
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Port Deposit Rural
c LENGTH OF STAY IN 1b: 2 Years
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Dr. Jack Rd.

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a STATE: Cecil Co. — b COUNTY: Md.
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Port Deposit Rural
d STREET ADDRESS: Dr. Jack Rd.
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: William — Middle: Rowland — Last: Christie
4 DATE OF DEATH: Month: May — Day: 1 — Year: 19 67
5 SEX: Male
6 COLOR OR RACE: White
7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8 DATE OF BIRTH: 3-15-1882
9 AGE (Years last birthday): 85 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Labor
10b KIND OF BUSINESS OR INDUSTRY: Farm Hand
BIRTHPLACE (State or foreign country): Maryland
CITIZEN OF WHAT COUNTRY?: U.S.A.
13 FATHER'S NAME: Robert Christie
14 MOTHER'S MAIDEN NAME: Mary S. Cooley
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown. If yes, give war or dates of service): No
16 SOCIAL SECURITY NO: [redacted] 215-32-4093
17 INFORMANT: Miss Frances Taylor Address: Conowingo Md.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c))
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: Yrs.
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): None Known
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c TIME OF INJURY: Month: April — Day: 5 — Year: 19 67 — Hour: am pm
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)
20f (City or town) (County) State

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Tillman D. Johnson M.D.
EXAMINER'S NAME (Type): Tillman D. Johnson M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town or county): Elkton Md.
22. DATE SIGNED: 5-1-67

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: 5-3-1967
23c NAME OF CEMETERY OR CREMATORY: West Nottingham Cem.
23d LOCATION (City or Town) (County) (State): Near Colora Cecil Md.
24 FUNERAL DIRECTOR: T.M. Mullan Lyon & Dir.
ADDRESS: Rising Sun, Md.
25a REC'D BY REGISTRAR: MAY 3 1967
25b REGISTRAR'S SIGNATURE: J. Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

96550 D6535

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH
a COUNTY: Cecil — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point, Md.
c LENGTH OF STAY IN 1b: 59 days
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): VAH Perry Point, Md.

2 USUAL RESIDENCE (Where deceased lived if institution: Residence before admission)
a STATE: District of Columbia — b COUNTY
c CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Washington, D.C.
d STREET ADDRESS: 4248 Dix St., N.E.
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: James — Middle: H. — Last: Cole
4. DATE OF DEATH: Month: May — Day: 28 — Year: 1967
5. SEX: Male
6. COLOR OR RACE: Negro
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 11 10 97
9. AGE (In years last birthday): 69 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Waiter
10b. KIND OF BUSINESS OR INDUSTRY: Restaurant
11. BIRTHPLACE (County & State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: James H. Cole Sr.
14. MOTHER'S MAIDEN NAME: Georgianna Taft
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes give war or dates of service): WW 1
16. SOCIAL SECURITY NO: 579-10-3350
17. INFORMANT: VA Hospital Records. — Address: Perry Point, Md.

MED CAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): BRONCHOPNEUMONIA — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): METASTATIC CARCER TO CERV. SPINE — 6 mo
DUE TO
(c): CANCER OF LT. LUNG — 1 year

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): QUADRUPLEGIA, DECUBITAL ULCERS
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (X) (this hospital) attended the deceased from 3-30 1967 to 5-28 1967 and that death occurred at 2:55 A.M., from causes and on the date stated above.

22a. SIGNATURE: Stephen A. Hegedus
M.D. ATTENDING PHYS ☑ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 5-28-67
22c. PHYSICIAN'S NAME (Type): STEPHEN A. HEGEDUS, M.D.
22d. ADDRESS: VA Hospital - Perry Point, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)
23b. DATE THEREOF: 6-2-67
23c. NAME OF CEMETERY OR CREMATORY: Baltimore Nat
23d. LOCATION (City or Town) (County) (State): Catonsville Md

24. FUNERAL DIRECTOR: H.S Washington & Son — ADDRESS: 4925 Bane One NE

25a. RECD BY REGISTRAR — DATE
25b. REGISTRAR'S SIGNATURE

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

C6551 — 06536

1. PLACE OF DEATH
a. COUNTY: Cecil
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rising Sun Rural
c. LENGTH OF STAY IN 1b: MARYLAND Life
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): R.F.D. # 1

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rising Sun Rural
d. STREET ADDRESS: R.F.D. # 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Nancy Middle Alice Last Cox

4. DATE OF DEATH: Month May Day 8, Year 1967

5. SEX: M Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: June 7, 1876
9. AGE (In years last birthday): 90 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife Ret.
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (County & State, or foreign country): Floyd Co. Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Costly Hill Puckett
14. MOTHER'S MAIDEN NAME: Mary Jane Jackson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
16. SOCIAL SECURITY NO.: ***********
17. INFORMANT Address: Virginia Mae Wiggins Rising Sun, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hypertensive C.V.D. & Arteriosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Coronary Occlusion
DUE TO (c): Senility

INTERVAL BETWEEN ONSET AND DEATH
(a) ? (b) ? (c) ?

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 4-24, 1962, to 5-8, 1962, that (I) (we) last saw the deceased alive on 5-8 1962, and that death occurred at 3:15 M, from the causes and on the date stated above.

22a. SIGNATURE (Physician) — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 5-10-67
22c. PHYSICIAN'S NAME (Type): G.H. Richards Md.
22d. ADDRESS: Port Deposit Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 5-11-1967
23c. NAME OF CEMETERY OR CREMATORY: Brookview Cem.
23d. LOCATION (City, town or county) (State): Rising Sun, Md.

24. FUNERAL DIRECTOR: Tyson Funeral Home
ADDRESS: Rising Sun, Md.
25a. REC'D BY REGISTRAR DATE: MAY 11 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

36552 — 68018

1 PLACE OF DEATH
a COUNTY: Cecil — MARYLAND
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Perry Point
c LENGTH OF STAY IN 1b: 8 days
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): VA Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a STATE: New Jersey — b COUNTY: Passaic
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Paterson
d STREET ADDRESS: 269 Kearney Street — e RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Bernadine — Middle: L. — Last: Crosby

4 DATE OF DEATH: Month: May — Day: 31, — Year: 1967

5 SEX: Female
6 COLOR OR RACE: White
7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8 DATE OF BIRTH: July 3, 1916
9 AGE (In years last birthday): 50 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life even if retired): Physio-Therapist
10b KIND OF BUSINESS OR INDUSTRY: Hospital
11 BIRTHPLACE (County & State or foreign country): Baltimore County, Maryland
12 CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: James Kelly
14. MOTHER'S MAIDEN NAME: Marie O'Farrell

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes give war or dates of service): WWII
16 SOC. A. SECURITY NO: 217-12-6671
17 INFORMANT — Address: VA Hospital Records, Perry Point, Md.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a) (b), and (c))
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Acute pulmonary edema — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last
(b): Arteriosclerotic heart disease
DUE TO
(c): Arteriosclerosis, generalized

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I a)

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. VA 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)
20f (City or Town) (County) (State)

21. I certify that (I) attended the deceased from May 23 , 1967 to May 31, , 1967 and that death occurred at 8:00 am from causes and on the date stated above.

22a SIGNATURE: [signature] M.D. ATTENDING PHYS ☐ MED DIRECTOR ☐ STAFF PHYS ☒
22b. DATE SIGNED: 6-1-67
22c PHYSICIAN'S NAME (Type): S. GOLDGRABEN, M.D.
22d. ADDRESS: VAH, Perry Point, Md.

23a BURIAL CREMATION REMOVAL (Specify): Burial
23b DATE THEREOF: 6/3/1967
23c NAME OF CEMETERY OR CREMATORY: Loudon Park Memorial Park
23d LOCATION (City or Town): Baltimore (County) (State): Md.

24 FUNERAL DIRECTOR: Lee A. Patterson & Son Funeral Home, Perryville, ADDRESS Maryland
25a. REC'D BY REGISTRAR: JUN 5 1967
25b REGISTRAR'S SIGNATURE: [signature] Judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

26553 — 06537

1 PLACE OF DEATH
a COUNTY: CECIL — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ELKTON
c. LENGTH OF STAY IN 1b: 4 DAYS
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): UNION HOSPITAL

2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission)
a. STATE: MD — b COUNTY: CECIL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CHESAPEAKE CITY
d. STREET ADDRESS: MOSS
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First HIRAM — Middle — Last EVERETT
4. DATE OF DEATH: Month 5 — Day 22 — Year 1967

5 SEX: MALE
6 COLOR OR RACE: WHITE
7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: 11-22-82
9 AGE (In years last birthday): 84 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RET. FARMER
10b KIND OF BUSINESS OR INDUSTRY: FARM
11 BIRTHPLACE (County & State or foreign country): MILLINGTON, MD.
12 CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: BENJAMIN J. EVERETT
14 MOTHER'S MAIDEN NAME: EMILY JANE COLE

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown) NO (If yes give war or dates of service)
16 SOCIAL SECURITY NO: 217-16-4729
17 INFORMANT: ANN ELIZABETH EVERETT — Address CHESAPEAKE CITY MD.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): PNEUMONIA — INTERVAL BETWEEN ONSET AND DEATH: 4 DAYS
DUE TO (b): CACHEXIA — 5 YEARS
DUE TO (c):
Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. — 493 X

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOT BY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c TIME OF INJURY Month, Day, Year — Hour a m / p m — 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg etc.)
20f (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from DEC 16, 19 66, to MAY 22, 19 67, that (I) (we) last saw the deceased alive on MAY 22 19 67, and that death occurred at 7:15 A.M., from causes and on the date stated above.

22a SIGNATURE: [signature] M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS ☐
22b DATE SIGNED: 5/23/67
22c. PHYSICIAN'S NAME (Type): H. [illegible] M.
22d. ADDRESS: CHESAPEAKE CITY MD

23a BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b DATE THEREOF: 5-25-67
23c NAME OF CEMETERY OR CREMATORY: BETHEL
23d LOCATION (City or Town) (County) (State): CHESAPEAKE CITY, MD.

24 FUNERAL DIRECTOR: PIPPIN FUNERAL HOME — ADDRESS: ELKTON, MD.
25a REC'D BY REGISTRAR DATE: MAY 25 1967
25b REGISTRAR'S SIGNATURE

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
20M S 63

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

06554 06538

1. PLACE OF DEATH
a. COUNTY: Cecil
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b: 16 yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Union Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Resident ... (Institution)
a. STATE: Maryland
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
d. STREET ADDRESS: 104 Walnut Lane
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: ANTHONY Middle: PETER Last: FABRIZI, Jr.
4. DATE OF DEATH: Month: May Day: 30 Year: 1967
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Sept. 2, 1950
9. AGE (In years last birthday): 16 yrs. IF UNDER 1 YEAR Months: Days: IF UNDER 24 HRS. Hours: Min.:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Elkton, Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: Anthony Peter Fabrizi, Sr.
14. MOTHER'S MAIDEN NAME: Jane Shepardson
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No
16. SOCIAL SECURITY NO.:
17. INFORMANT Address: Anthony Peter Fabrizi, Sr, Elkton, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a) (b), and (c).)
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) [illegible]
DUE TO (b) [illegible]
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) [illegible]
INTERVAL BETWEEN ONSET AND DEATH: 8 [illegible]
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from [illegible], 19[illegible] to [illegible], 19[illegible], that (I) (we) last saw the deceased alive on [illegible], 19[illegible], and that death occurred at [illegible] P.M. from the causes and on the date stated above.

22a. SIGNATURE [illegible] M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 5/31/67
22c. PHYSICIAN'S NAME (Type): Joseph C. Lanzi, M.D.
22d. ADDRESS: Elkton Medical Park, Elkton, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: June 2, 1967
23c. NAME OF CEMETERY OR CREMATORY: Immaculate Conception
23d. LOCATION (City, town or county) (State): Cherry Hill, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Hicks Home for Funerals, Elkton, Md.
25a. REC'D BY REGISTRAR DATE: JUN 5 1967
25b. REGISTRAR'S SIGNATURE

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5) 6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06555 — 06539

PLACE OF DEATH
a COUNTY: Cecil — STATE: MARYLAND
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Elkton
c LENGTH OF STAY IN: D.O.A.
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Union Hospital

2 USUAL RESIDENCE (Where deceased lived. Enter Institution. Residence before admission)
a STATE: Md. — b COUNTY: Cecil
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural — Elkton
d STREET ADDRESS: Cherry Hill R.D. 5 (Elkton)
e IS RESIDENCE ON A FARM? YES ☐ NO ☑

1

3. NAME OF DECEASED (Type or print): First: Elsie — Middle: Lorenda — Last: Gallimore
4. DATE OF DEATH: Month: 5 — Day: 24 — Year: 1967
5. SEX: F.
6. COLOR OR RACE: W.
7. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 9-5-55
9. AGE (In years last birthday): 11 yrs — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HR.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired): Student
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): Havre de Grace, Md.
12. CITIZEN OF WHAT COUNTRY?: U.S.
13. FATHER'S NAME: John Gallimore
14. MOTHER'S MAIDEN NAME: Alvenia —
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, or Unknown. If yes give war or dates of service): No
16. SOCIAL SECURITY NO: None
17. INFORMANT: Mrs. Alvenia Nycum — Address: R.D. #5 Elkton Md. 120x137

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Multiple Severe Injuries — INTERVAL BETWEEN ONSET AND DEATH: Immed.
DUE TO (b): (collision with auto while
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO (c): riding bicycle)

PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. EXTERNAL CAUSE WAS PRIMARY ☑ or CONTRIBUTING ☐ CAUSE OF DEATH
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): struck by car while riding bicycle on hwy.
20c. TIME OF INJURY Month Day Year: Hour 7:53 pm — 5-24 1967
20d. INJURY OCCURRED While at work ☐ Not While at work ☑
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Rte 280 (Hwy)
20f. City or town (County) (State): Near Cherry Hill, Cecil, Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☑ and in my opinion death resulted from Natural causes ☐, Accident ☑, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: John M. Byers, M.D.
EXAMINER'S NAME (Type): John M. Byers, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☑
Address (Street, city, town, or county): Elkton, Md.
22. DATE SIGNED: 5-24-67

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 5-27-67
23c. NAME OF CEMETERY OR CREMATORY: Gilpin Manor Mem. Pk.
23d. LOCATION (City or Town) (County) (State): Elkton Cecil Md.
24. FUNERAL DIRECTOR — ADDRESS: Pippin Funeral Home — Elkton, Md.
25a. REC'D BY REGISTRAR — DATE:
25b. REGISTRAR'S SIGNATURE:

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

36556 — 06540

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

VR A15 (4)
25M 1/67

PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point
c. LENGTH OF STAY IN 1b: 6 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): VA Hospital

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town): Havre De Grace
d. STREET ADDRESS: 653 Green St.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: James — Middle: W. — Last: GIBSON
4. **DATE OF DEATH**: Month: MAY — Day: 30 — Year: 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 6-24-00
9. AGE (In years last birthday): 66 yrs — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Civil Service
10b. KIND OF BUSINESS OR INDUSTRY: RETIRED Civil Service
11. BIRTHPLACE (County & State, or foreign country): Philadelphia Pa.
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Ernest H. Gibson (D)
14. MOTHER'S MAIDEN NAME: Elizabeth HACKNEY (D)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes give war or dates of service): WW II
16. SOCIAL SECURITY NO.: 220-07-87-79
17. INFORMANT: VA Hospital Records — Address: Perry Point, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Bronchopneumonia, bilateral — INTERVAL BETWEEN ONSET AND DEATH: 3-5 days
DUE TO (b): Cerebral hemorrhage, massive — 6-7 days
Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last — DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year, Hour, a.m. p.m., 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that I (this hospital) attended the deceased from 5-24-67, 19 to 5/30/, 19 67 and that (I) (we) last saw the deceased alive on ____, and that death occurred at 10:20 pm from causes and on the date stated above

22a. SIGNATURE: [signature] M.D. ATTENDING PHYS. ☐ MED DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 5-31-67
22c. PHYSICIAN'S NAME (Type): S. GOLDGRABEN, M.D.
22d. ADDRESS: VA Hospital - Perry Point, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: JUNE 2 1967
23c. NAME OF CEMETERY OR CREMATORY: Angel Hill Cemetery
23d. LOCATION (City or Town) (County) (State): Havre deGrace Md. Harford Co. Maryland

24. FUNERAL DIRECTOR: R. Madison Mitchell, 123 W. Washington St., — ADDRESS: Havre de Grace, Md.
25a. REC'D BY REGISTRAR — DATE: JUN 2 1967
25b. REGISTRAR'S SIGNATURE: [signature] Deputy Judge

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word pending in pencil in Item 18 G ve Pages 1 2 and 3 to the funeral director Page 4 should be forwarded to the Chief Medical Examiners Office a ang with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06557 — 06541

1 PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): North East
c. LENGTH OF STAY IN 1b: 2 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): R.D. 1

2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before)
a. STATE: Maryland
b. COUNTY: Cecil
CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): North East
d. STREET ADDRESS: R.D. 1
e. RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First RUTH — Middle EVELYN — Last HARPER

4 DATE OF DEATH: Month May — Day 5 — Year 19 67

5 SEX: Female

6 COLOR OR RACE: White

7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

8 DATE OF BIRTH: Sept. 11, 1900

AGE (Last birthday) XXX yrs — IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.

10a TRADE, PROFESSION, OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b KIND OF BUSINESS OR INDUSTRY: Home

11 BIRTHPLACE (State or foreign country): Maryland

12 CITIZEN OF WHAT COUNTRY? USA

13 FATHER'S NAME: Robert Lee Harper

14 MOTHER'S MAIDEN NAME: Della Miller

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown, if yes give war or dates of service)

16 SOCIAL SECURITY NO: None

17 INFORMANT: Steele, R. Harper Jr. — Address: Elkton, Md.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Gunshot wound of neck and spinal cord
DUE TO
(b):
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18): Shot during altercation.

20c TIME OF INJURY Month, Day, Year: Hour XX pm — 5/5 — 19 67

20d INJURY OCCURRED: While at work ☐ Not While at work ☒

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home

20f (City or town) North East — (County) Cecil — (State) Md.

21 I certify that I took charge of the remains described above held on Autopsy ☒, Inspection ☐, Inquiry ☐ and in my opinion death resulted from Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☒, Undetermined manner ☐

ACTUAL SIGNATURE: Charles S. Petty, M.D.
EXAMINER'S NAME (Type): Charles S. Petty
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐
Address (Street, city, town or county)

22 DATE SIGNED: 5/6/67

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: 5/10/67
23c NAME OF CEMETERY OR CREMATORY: North East Methodist
(City or town): North East — (County): Cecil — (State): Md.

24 FUNERAL DIRECTOR: Grant Funeral Home — Fred M. Crouch
ADDRESS: North East, Md.

25a RECD BY REGISTRAR DATE: MAY 9 1967

25b REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15ME (5) 6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

CC558 — 06542

1 PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point
c. LENGTH OF STAY IN 1b: 1 mo 12 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Veterans Administration Hospital

2 USUAL RESIDENCE (Where deceased lived if institution. Residence before admission)
a. STATE: District of Columbia — b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 1717 Q Street, N. W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First GEORGE — Middle E. — Last HICKS
4 DATE OF DEATH: Month May — Day 18 — Year 19 67
5 SEX: Male
6 COLOR OR RACE: White
7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8 DATE OF BIRTH: 9-23-92
9 AGE (In years last birthday): 74 yrs
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk
10b. KIND OF BUSINESS OR INDUSTRY:
11 BIRTHPLACE (County & State, or foreign country): Virginia
12 CITIZEN OF WHAT COUNTRY? U.S.A.
13 FATHER'S NAME: Benjamin F. Hicks (D)
14 MOTHER'S MAIDEN NAME: Sarah E. Jackson (D)
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): Yes — (If yes give war or dates of service): WW I
16. SOCIAL SECURITY NO.: 579-18-4271
17 INFORMANT — Address: VA Hospital Records, Perry Point, Md.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Acute pulmonary edema — INTERVAL BETWEEN ONSET AND DEATH: sudden
DUE TO
Conditions if any which gave rise to immediate cause (a), stating the underlying cause last
(b): Arteriosclerotic heart disease — years
DUE TO
(c): Arteriosclerosis, generalized — years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.
19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21 I certify that (X) (this hospital) attended the deceased from April 6, 19 67 to May 18 1967 [illegible] and that death occurred at 6:50 am, from causes and on the date stated above.

22a SIGNATURE: SEYMOUR GOLDGRABEN — M.D. ☐ ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b DATE SIGNED: 5-18-67
22c PHYSICIAN'S NAME (Type): SEYMOUR GOLDGRABEN
22d ADDRESS: VA Hospital, Perry Point, Md.

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: May 22, 1967
23c NAME OF CEMETERY OR CREMATORY: Washington National
23d LOCATION (City or Town) (County) (State): Maryland
24. FUNERAL DIRECTOR — ADDRESS: W.W. CHAMBERS FUNERAL HOME, WASHINGTON, DC
25c. REC'D BY REGISTRAR DATE: MAY 25 1967
25E. REGISTRAR'S SIGNATURE:

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

VR A15 (4)
25M 1/67

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

36553

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06543

1 PLACE OF DEATH
a. COUNTY: CECIL
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): ELKTON
LENGTH OF STAY IN MARYLAND: D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Union Hospital

2 USUAL RESIDENCE (Where deceased lived and usually kept house)
a. STATE: Maryland
b. COUNTY: CECIL
c. CITY OR TOWN (If outside corporate limits write RURAL): Pleasant Hill, Elkton
d. STREET ADDRESS: R.D.3 (box 216-A)
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First ROBERT Middle EDWARD Last HILAMAN, Jr.
4 DATE OF DEATH: Month May Day 7, Year 19 67
5 SEX: Male
6 COLOR OR RACE: White
7 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: June 2, 1965
9 AGE (Last birthday): 1
UNDER 1 YEAR: Months 11 Days Hours Min.
IF UNDER 24 HRS.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ----
10b KIND OF BUSINESS OR INDUSTRY: -----
11 BIRTHPLACE (State or foreign country): Maryland
12 CITIZEN OF WHAT COUNTRY? U.S.A.

13 FATHER'S NAME: Robert Edward Hilaman
14 MOTHER'S MAIDEN NAME: Susan L. Church

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No
16 SOCIAL SECURITY NO: ---
17 INFORMANT: Robert E. Hilaman, Elkton, Md. Address: R.D. # 3

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Acute epiglottitis and laryngitis
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
INTERVAL BETWEEN ONSET AND DEATH

PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I
AUTOPSY PERFORMED YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21 I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Charles T. Springate M.D.
EXAMINER'S NAME (Type): Charles S. Springate, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐
Address (Street, city, county): [illegible]
22. DATE SIGNED: May 8, 1967

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: 5/10/67.
23c NAME OF CEMETERY OR CREMATORY: Cherry Hill Methodist
[illegible] City, State: Cherry Hill, Md.

24 FUNERAL DIRECTOR: Ralph E. Hicks
ADDRESS: Hicks Home for Funerals, Elkton, Md.
25a. RECD BY REGISTRAR DATE: MAY 15 1967
25b REGISTRAR'S SIGNATURE: J. Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
5M 1/63

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06560 — 06544

1. PLACE OF DEATH
a. COUNTY: Cecil
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Elkton
c. LENGTH OF STAY IN 1b: 6 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): R.D. 1

2. USUAL RESIDENCE (Where deceased lived, if institution, Resident's before admission)
a. STATE: Maryland
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural, Elkton
d. STREET ADDRESS: R.D. 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First EDWARD Middle J. Last FINNEY

4. DATE OF DEATH: Month 5 Day 15 Year 1967

5. SEX: M

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Sept. 1, 1

9. AGE (In years last birthday): yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mechanic

10b. KIND OF BUSINESS OR INDUSTRY: Transportation

11. BIRTHPLACE (State or foreign country): Rowlesburg W. Va.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John B. Jianniney

14. MOTHER'S MAIDEN NAME: Sally Sheets

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: [illegible]

17. INFORMANT: Ruth E. J[illegible]
Address: R.D. 1 Elkton, Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CIRRHOSIS OF THE LIVER
DUE TO (b): CHRONIC ALCOHOLISM
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: Several Years

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.): DIED IN BED

20c. TIME OF INJURY: Hour a.m. 6:30 p.m. Month, Day 5/15 Year 67

20d. INJURY OCCURRED: While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): HOME

20f. (City or town) RT 1 ELKTON (County) CECIL (State) MD

21. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and in my opinion death resulted from. Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: [signature] M D

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): HENRY L. DAVIS MD

Address (Street, city, town, or county):

DATE SIGNED: 5/16/67

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 5/[illegible]/67

22c. NAME OF CEMETERY OR CREMATORY: North East Memorial

22d. LOCATION (City, town or county) (State): North East, Md.

23. FUNERAL DIRECTOR: Paul R. Crouch

ADDRESS: P.O. Box 2 North East, Md.

24a. REC'D BY REGISTRAR DATE: MAY 17 1967

24b. REGISTRAR'S SIGNATURE: J. Charles Judge

1

M

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06561

CERTIFICATE OF DEATH

06545

1 PLACE OF DEATH a. COUNTY: Cecil, MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point
c LENGTH OF STAY IN 1b: 23 days / 1 yr 5 mos
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Veterans Administration Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a STATE: Maryland
b COUNTY: HARF. CO.
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace
d STREET ADDRESS: 669 Revolution Street
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First DANIEL, Middle F., Last KIMBALL
4 DATE OF DEATH: Month May, Day 14, Year 1967

5 SEX: Male
6 COLOR OR RACE: White
7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8 DATE OF BIRTH: 1-21-78
9 AGE (in years last birthday): 89 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Auto mechanic
10b KIND OF BUSINESS OR INDUSTRY: RETIRED
11 BIRTHPLACE (County & State or foreign country): Hartford Co., Md.
12 CITIZEN OF WHAT COUNTRY?: U.S.A.

13 FATHER'S NAME: Samuel C. (D) KIMBALL
14 MOTHER'S MAIDEN NAME: Annie R. Bradford (D)

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes give war or dates of service): S A W
16 SOCIAL SECURITY NO: 217-54-7552
17 INFORMANT / Address: VA Hospital Records, Perry Point, Md.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c))
PART I DEATH WAS CAUSED BY — INTERVAL BETWEEN ONSET AND DEATH

	Cause	Interval
IMMEDIATE CAUSE (a)	Bronchopneumonia, bilateral	1-2 weeks
DUE TO (b)	Arteriosclerotic heart disease and	years
xxxx	Obstructive uropathy	
(c)	Very enlarge prostate	years

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Anemia, severe (refractory)

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c TIME OF INJURY Month, Day, Year 19 — Hour a.m. p.m.
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21 I certify that ~~I~~ (this hospital) attended the deceased from Nov. 22, 1965 to May 14, 1967 xxxxxxxx xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx and that death occurred at 10:35 pm from causes and on the date stated above

22a SIGNATURE: S. Goldgraben M.D. — ATTENDING PHYS ☐ MED DIRECTOR ☐ STAFF PHYS ☒
22b DATE SIGNED: 5-15-67
22c PHYSICIAN'S NAME (Type): S. GOLDGRABEN, M.D.
22d ADDRESS: VA Hospital, Perry Point, Md.

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: May 17, 1967
23c NAME OF CEMETERY OR CREMATORY: Angel Hill Cem.
23d LOCATION (City or Town) (County) (State): Havre de Grace, Md

24 FUNERAL DIRECTOR: R. Madison Mitchell — ADDRESS: Maryland
Madison-Mitchell Funeral Home, Havre de Grace
25a REC'D BY REGISTRAR: MAY 18 1967
25b REGISTRAR'S SIGNATURE: [illegible signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with n 24 hours after death Page 4 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06562

CERTIFICATE OF DEATH

06546

1 PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): North East
c. LENGTH OF STAY IN: Life
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): R.D. # 1

2 USUAL RESIDENCE (Where deceased lived if institution. Residence before admission)
a. STATE: Maryland
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): North East
d. STREET ADDRESS: R.D. # 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Joseph — Middle: M. — Last: Kinslow

4 DATE OF DEATH: Month: May — Day: 8 — Year: 19 67

5 SEX: Male

6 COLOR OR RACE: Negro

7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: Nov. 18, 1891

9 AGE (In years last birthday): 75 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b KIND OF BUSINESS OR INDUSTRY: B. & O. R.R.

11 BIRTHPLACE (County & State or foreign country): Maryland

12 CITIZEN OF WHAT COUNTRY?: U.S.A.

13 FATHER'S NAME: Henry T. Kinslow

14 MOTHER'S MAIDEN NAME: Margaret L. Hammond

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 220-12-9611

17 INFORMANT: Mrs. Blanche Kinslow, North East, Md — Address: R.D. # 1

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c))
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Acute Hydronephrosis — INTERVAL BETWEEN ONSET AND DEATH: 7-Days
DUE TO (b): Diabetes, Chronic Nephritis — 10-Years
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d INJURY OCCURRED While at work ☐ Not While at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21 **I certify** that (I) (My associate) attended the deceased from 1/4/, 19 67, to 5/8/, 19 67, that (I) (We) last saw the deceased alive on 5/8/ 19 67, and that death occurred at 9:30 A.M., from causes and on the date stated above.

22a SIGNATURE: James L. Johnson — MD ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS ☐

22b DATE SIGNED: 5/9/67

22c PHYSICIAN'S NAME (Type): James L. Johnson M.D.

22d. ADDRESS: 245 East High St., Elkton Cecil Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b DATE THEREOF: 5/11/67

23c NAME OF CEMETERY OR CREMATORY: Trinity Cemetery

23d LOCATION (City or Town) (County) (State): Zion, Cecil Co. Md.

24. FUNERAL DIRECTOR: Hicks Home for Funerals — ADDRESS: Elkton, Md.

25a. REC'D BY REGISTRAR DATE: MAY 15 1967

25b REGISTRAR'S SIGNATURE: Juliana Jusge

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

36563

CERTIFICATE OF DEATH

06547

1 PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perryville
c LENGTH OF STAY IN 1b: 20 days
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Perry Point V.A. Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a. STATE: Maryland — b COUNTY: Harford
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rocks
d STREET ADDRESS: North Bend Road
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First ROBERT Middle J. Last KNOPP
4 DATE OF DEATH: Month May Day 21 Year 19 67

5 SEX: Male
6 COLOR OR RACE: White
7 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: 9-5-22
9 AGE (In years last birthday): 44 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b KIND OF BUSINESS OR INDUSTRY: Ammunition
11 BIRTHPLACE (County & State, or foreign country): Rocks Harford MD
12 CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Joseph Knopp
14 MOTHER'S MAIDEN NAME: Mary Dick

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes (If yes, give war or dates of service): WW II
16. SOCIAL SECURITY NO.: 218 14 92 74
17 INFORMANT: Wilson A. Knopp (VA Records) Address: Rocks, Md. Perry Point, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary edema w/pleural effusion
DUE TO (b): Hepatic insufficiency
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO (c): Cirrhosis of liver (Laennec's)
INTERVAL BETWEEN ONSET AND DEATH

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21 I certify that (I) (this hospital) attended the deceased from 5-1-, 19 67, to 5-21-, 1967 xxxxxxxxxxxx saw the deceased xxxxxxxxxxxxxxxxxxxxxxxx, and that death occurred at 7:50 PM, from causes and on the date stated above

22a SIGNATURE: S. Goldgraben
M.D. ATTENDING PHYS ☐ MED DIRECTOR ☐ STAFF PHYS ☒
22b DATE SIGNED: 5-22-67
22c. PHYSICIAN'S NAME (Type): S. GOLDGRABEN, M.D.
22d ADDRESS: VAH, Perry Point, Md., 21902

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: 5-26-67
23c NAME OF CEMETERY OR CREMATORY: Bel Air Memorial Garden
23d LOCATION (City or Town) (County) (State): Bel Air Harford Md.

24 FUNERAL DIRECTOR ADDRESS: MARTIN KURTZ & SON JARRETTSVILLE, MD.
25a REC'D BY REGISTRAR DATE: MAY 24 1967
25b REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with in 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06564 (M) 06548

1 PLACE OF DEATH
a. COUNTY: CECIL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ELKTON
c. LENGTH OF STAY IN This: 1 DAY
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): UNION HOSPITAL

2 USUAL RESIDENCE (Where deceased lived, If institution Residence before admission)
a. STATE: MD — b. COUNTY: CECIL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ELKTON
d. STREET ADDRESS: 231 E. MAIN
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First JOHN — Middle A. — Last LOVELESS

4 DATE OF DEATH: Month 5 — Day 15 — Year 1961

5 SEX	6 COLOR OR RACE	7 MARITAL STATUS	8 DATE OF BIRTH	9 AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS: Hours / Min.
M	W	MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	3-14-1895	72 yrs		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
RET. RIDE	V.A. HOSPITAL	CHESAPEAKE CITY, MD	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
DALLAS V LOVELESS	KATHERINE R LLOYD.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
NO	217-20-5311A	FRED B LOVELESS	R D #1 ELKTON, MD

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Acute myocardial insufficiency — INTERVAL BETWEEN ONSET AND DEATH: 24 hrs
DUE TO
(b): Arteriosclerotic Heart Disease — years
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
4 J C

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or Town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 5-14-61, 19 67, to 5-17-67, 19 67 that (I) (we) last saw the deceased alive on 5-15-67, 19 67, and that death occurred at 2:24 M, from causes and on the date stated above

22a. SIGNATURE	M.D	ATTENDING PHYS. ☒	MED. DIRECTOR ☐	STAFF PHYS ☐	22b. DATE SIGNED
J. Herman Johnson					5-17-67

22c. PHYSICIAN'S NAME (Type)	22d. ADDRESS
Edmund D. Johnson M.D	123 Singerly Ave, Elkton, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
BURIAL	5-17-67	BETHEL	CHESAPEAKE CITY MD

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
PIPPIN FUNERAL HOME	ELKTON, MD	DATE MAY 18 1967	

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

26565 06549

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Than please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH — a. COUNTY: Cecil — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Calvert,
   c. LENGTH OF STAY IN: 1b: 20 Months
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Calvert Manor Nursing Home

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) — a. STATE: Penna. — b. COUNTY: Chester
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Oxford
   d. STREET ADDRESS: 111 S. Fourth St.
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Mrs Mary — Middle: A. — Last: McMahon

4. DATE OF DEATH: Month: May — Day: 14, — Year: 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 6-24-1883

9. AGE (In years last birthday): 83 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Mushroom Cannery

11. BIRTHPLACE (County & State, or foreign country): Lionville, Chester Co

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Edward Keeley

14. MOTHER'S MAIDEN NAME: Mary Carney

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No.

16. SOCIAL SECURITY NO.: 181-20-5762D

17. INFORMANT: David W. McMahon — Address: 26 S. Fourth St Oxford, Pa.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Pulmonary embolus — [illegible]

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b): Carcinoma [illegible] — 6 mo.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

Carcinoma [illegible]

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Dec 6, 19--, to 3-14, 19--, that (I) (we) last saw the deceased alive on 3-14 19--, and that death occurred at 5 1/2 M, from the causes and on the date stated above.

22a. SIGNATURE: [signature] — M.O. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 5-15-67

22c. PHYSICIAN'S NAME (Type): C. J. Hancock MD

22d. ADDRESS: Oxford, Pa.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 5-17-1967

23c. NAME OF CEMETERY OR CREMATORY: St. Marys Cemetery

23d. LOCATION (City, town or county) (State): West Grove, Penna.

24. FUNERAL DIRECTOR: William G. Johnston — ADDRESS: Oxford, Penna.

25a. REC'D BY REGISTRAR DATE: MAY 17 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (4)
15M 4-64

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with n 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physic an and completely filled in by the funeral director, page 3 should be detached for use as the burial-trans t permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

36566

CERTIFICATE OF DEATH

06550

1 PLACE OF DEATH
a COUNTY: Cecil — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Colora Rural
c LENGTH OF STAY IN 1b: 10 ½ Years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a STATE: Md. — b COUNTY: Cecil
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Colora Rural
d STREET ADDRESS:
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First Marie · Middle Evans · Last Morgan

4 DATE OF DEATH: Month May · Day 26 · Year 1967

5 SEX: Female
6 COLOR OR RACE: White
7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: 2-11-1928
9 AGE (In years last birthday): 39 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife
10b KIND OF BUSINESS OR INDUSTRY: Own Home
11 BIRTHPLACE (County & State or foreign country): Radford Virginia
12 CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Allen Evans Croy
14 MOTHER'S MAIDEN NAME: Grace Powers

15 WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No
16 SOCIAL SECURITY NO: 231-24-6525
17 INFORMANT: Frank Morgan — Address: Colora Md.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Uremia-Gastric — INTERVAL BETWEEN ONSET AND DEATH: 6 Hrs
DUE TO
(b): Hemorrhage — 10 days
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21 I **certify** that ( ) (this hospital) attended the deceased from 5-15, 1967 to 5-26, 1967, that (I) (we) last saw the deceased alive on 5-26, 1967, and that death occurred at 3:00 P.M., from causes and on the date stated above.

22a SIGNATURE: [signature] M.D. ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS ☐
22b DATE SIGNED: 5/27/67
22c PHYSICIAN'S NAME (Type): G. H. Richards Jr. MD
22d ADDRESS: Port Deposit Md.

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: 5-29-1967
23c NAME OF CEMETERY OR CREMATORY: West Nottingham Cem.
23d LOCATION (City or Town) (County) (State): Colora Cecil Md.

24 FUNERAL DIRECTOR: [signature] Dir. Tyson F.H. ADDRESS: Rising Sun, Md.
25a REC'D BY REGISTRAR DATE: MAY 31 1967
25b REGISTRAR'S SIGNATURE: [signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06567

CERTIFICATE OF DEATH

06551

1 PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Elkton
c LENGTH OF STAY IN 1b:
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Union Hospital

2 USUAL RESIDENCE (Where deceased lived if institution. Residence before admission)
a STATE: Md. — b COUNTY: Kent.
c CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Massey.
d STREET ADDRESS:
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Helen — Middle: W. — Last: Linker
4 DATE OF DEATH: Month: 5 — Day: 1 — Year: 19[illegible]

5 SEX: Female
6 COLOR OR RACE: White
7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8 DATE OF BIRTH: December, 11, 1881
9 AGE (In years last birthday): 85 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife.
10b KIND OF BUSINESS OR INDUSTRY: Own Home.
11 BIRTHPLACE (County & State or foreign country): Md.
12 CITIZEN OF WHAT COUNTRY? U.S.A.

13 FATHER'S NAME: Edward A. Woodall.
14 MOTHER'S MAIDEN NAME: Agnes Kraft.

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No.
16 SOCIAL SECURITY NO: 214-46-4718
17 INFORMANT: Daughter. Address: Mrs. Marie Moffett, Galena, Md. 21635

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerosis, gen. [illegible]
DUE TO
(b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — DUE TO
(c)
INTERVAL BETWEEN ONSET AND DEATH

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from [illegible], 19[illegible], to [illegible], 19[illegible], that (I) (we) last saw the deceased alive on [illegible], 19[illegible], and that death occurred at [illegible] M, from causes and on the date stated above

22a SIGNATURE: [illegible] M.D. ATTENDING PHYS ☑ MED DIRECTOR ☐ STAFF PHYS ☐
22b DATE SIGNED: 5/1/67
22c PHYSICIAN'S NAME (Type): [illegible]
22d. ADDRESS: ELKTON, MARYLAND

23a BURIAL, CREMATION, REMOVAL (Specify): Burial.
23b DATE THEREOF: May, 3, 1967
23c NAME OF CEMETERY OR CREMATORY: Galena Cemetery.
23d LOCATION (City or Town) (County) (State): Galena, Kent Co; Md.

24 FUNERAL DIRECTOR: Edward Fellows,
ADDRESS: Millington, Md. 21651
25a RECD BY REGISTRAR DATE: MAY 4 1967
25b REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06568 06552

PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point
c. LENGTH OF STAY IN b: 2 years, 1 month, 5 days

2 USUAL RESIDENCE (Where deceased lived if institution. Residence before admission)
a. STATE: DISTRICT OF COLUMBIA — b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 2101 16th St. N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): VA Hospital

3 NAME OF DECEASED (Type or print) First	Middle	Last	4 DATE OF DEATH Month	Day	Year
Mary	U.	PIERCE	May	4	1967

5 SEX	6 COLOR OR RACE	7 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9 AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS Hours / Min
Female	White		5-14-95	71 yrs		

10a USUAL OCCUPATION (Give kind of work done during most of working life even if retired)	10b KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (County & State, or foreign country)	12 CITIZEN OF WHAT COUNTRY?
Clerk	clerical	Hopkinton, Mass.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
John F. Pierce	Anna Welch

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16 SOCIAL SECURITY NO	17 INFORMANT Address
Yes WWI	059-03-7221	VA Hospital Records - Perry Point, Maryland

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Arteriosclerotic Coronary Heart Disease,
DUE TO (b): Severe
Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last
DUE TO (c): Acute Myocardial Infarction

INTERVAL BETWEEN ONSET AND DEATH: Years

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.	20d INJURY OCCURRED While at work ☐ Not While at work ☐	20e PLACE OF INJURY (Home, farm factory, street office bldg. etc.)	20f (City or town) (County) (State)
VA 19			

21 I certify that I (attended) the deceased from 3-29-65, 19__ pm to 5-4-67, 19__ and that death occurred at 11:05 M, from causes and on the date stated above

22a SIGNATURE	ATTENDING PHYS ☐ MED DIRECTOR ☐ STAFF PHYS ☒	22b DATE SIGNED
M.D.		5-6-67

22c. PHYSICIAN'S NAME (Type)	22d. ADDRESS
B. ROTHFELD, M.D.	VA Hospital - Perry Point, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
Burial	May 8 1967	Mt. Benedict	Baltimore Md.

24 FUNERAL DIRECTOR	ADDRESS	25a REC'D BY REGISTRAR DATE	25b REGISTRAR'S SIGNATURE
[illegible] for Howard Grace Mgr		MAY 12 1967	Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

vR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06563

CERTIFICATE OF DEATH

06553

1 PLACE OF DEATH
a COUNTY: Cecil — MARYLAND
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Perry Point
c LENGTH OF STAY IN: 1 day
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Veterans Administration Hospital

2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission)
a STATE: Maryland
b COUNTY:
c CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Baltimore
d STREET ADDRESS: 1604 Latrobe Street
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First RICHARD — Middle — Last PIERCE

4 DATE OF DEATH: Month May — Day 16 — Year 19 67

5 SEX: Male

6 COLOR OR RACE: Negro

7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8 DATE OF BIRTH: 7-25-12

9 AGE (In years last birthday): 54 yrs
If UNDER 1 YEAR: Months — Days
If UNDER 24 HRS: Hours — Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Brick layer

10b KIND OF BUSINESS OR INDUSTRY:

11 BIRTHPLACE (County & State or foreign country): Stevensville, Md.

12 CITIZEN OF WHAT COUNTRY? U.S.A.

13 FATHER'S NAME: William (D)

14 MOTHER'S MAIDEN NAME: Maude Gross (D)

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes give war or dates of service): WW II

16 SOC. A. SECURITY NO: 216-12-1573

17 INFORMANT: VA Hospital Records, Perry Point, Md.
Address

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a): Pneumonia
DUE TO
(b):
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
493 X

INTERVAL BETWEEN ONSET AND DEATH

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c TIME OF INJURY Month, Day, Year: Hour a.m. p.m. 19

20d INJURY OCCURRED While at work ☐ Not While at work ☐

20e PLACE OF INJURY (Home farm factory, street office bldg etc.)

20f (City or town) (County) (State)

21 I certify that (this hospital) attended the deceased from May 16, 1967 to May 16, 1967 that (I) saw the deceased alive on [illegible], and that death occurred at 3:25 pm from causes and on the date stated above

22a SIGNATURE:
M.D. ATTENDING PHYS ☐ MED DIRECTOR ☐ STAFF PHYS ☒

22b DATE SIGNED: 5-16-67

22c PHYSICIAN'S NAME (Type):

22d ADDRESS: VA Hospital, Perry Point, Md.

23a BURIAL, CREMATION, REMOVAL (Specify): Burial Removal

23b DATE THEREOF: 5-19-67

23c NAME OF CEMETERY OR CREMATORY: Baltimore National

23d LOCATION (City or Town) (County) (State): Baltimore, Maryland

24 FUNERAL DIRECTOR: Marshall Jones
ADDRESS: 1735 N. Harford Ave., Balt, Md.

25a REC'D BY REGISTRAR (DATE): MAY 22 1967

25b REGISTRAR'S SIGNATURE: J. Charles Judge

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

06570 — 06554

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH — a. COUNTY: Cecil — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
   c. LENGTH OF STAY IN 1b: Life 3 yrs
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Union Hospital of Cecil County

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) — a. STATE: Maryland — b. COUNTY: Cecil
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Northeast, ,Maryland
   d. STREET ADDRESS: R.D. 1
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: ~~Cecelia~~ Celia — Middle: B — Last: Preston

4. DATE OF DEATH: Month: May — Day: 9 — Year: 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 11/8/93

9. AGE (In years last birthday): 73 yrs. — IF UNDER 1 YEAR: Months / Days / IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Dennison

14. MOTHER'S MAIDEN NAME: Rose Lilly

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: ~~[illegible]~~ -5- 1~~[illegible]~~

17. INFORMANT: Mrs. Celia Lerns (Daughter) — Address: Northeast, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Pulmonary Edema, Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: 2- Days

Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.

DUE TO (b): Ruptured Spleen — 2- Days

DUE TO (c): Paralytic Ileus and Fractured Ribs — 2- Days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☒ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.): Automobile Accident

20c. TIME OF INJURY Month, Day, Year: Hour 11 a.m. p m. — 5/7/1967

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Highway

20f. (City or town) (County) (State): Cecil Md.

21. I certify that (I) (this hospital) attended the deceased from 5/7/ , 1967 to 5/9/ , 1967 that (I) (we) last saw the deceased alive on 5/9/ 1967, and that death occurred at 10:20 P.M. from the causes and on the date stated above.

22a. SIGNATURE: James L. Johnson — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 5/12/67

22c. PHYSICIAN'S NAME (Type): James L. Johnson M.D.

22d. ADDRESS: 245 E. High St., Elkton, Md. Cecil

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 5/12/67

23c. NAME OF CEMETERY OR CREMATORY: North East Methodist Cem.

23d. LOCATION (City, town or county) (State): North East, Md.

24. FUNERAL DIRECTOR: Frank R. Crouch — Grant Funeral Home — ADDRESS: North East, Md.

25a. REC'D BY REGISTRAR — DATE: MAY 16 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (4) 20M 1/65

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

26571 — 06555

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): [illegible] Elkton
c. LENGTH OF STAY IN 1b: 4 mos.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): R.D. 1

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): North East
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First [illegible] Middle [illegible] Last REED

4. DATE OF DEATH: Month [illegible] Day [illegible] Year 19

5. SEX: [illegible] — 6. COLOR OR RACE: [illegible] — 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ — 8. DATE OF BIRTH: [illegible] — 9. AGE (In years last birthday): [illegible] yrs. — IF UNDER 1 YEAR: Months [illegible] Days [illegible] — IF UNDER 24 HRS.: Hours [illegible] Min. [illegible]

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (County & State, or foreign country): Philadelphia Co. Penna.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Heidick
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Frank C. Reed — Address: R.D. 1 Box 10[illegible] Elkton, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Atherosclerosis — INTERVAL BETWEEN ONSET AND DEATH: 12 yrs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Hypertensive Cardiovascular Disease — 20 years
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from June, 1967, to 12 May, 1967, that (I) (we) last saw the deceased alive on 8 May 1967, and that death occurred at 7:30 A.M., from the causes and on the date stated above.

22a. SIGNATURE: Klaus H. Huebner — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 5/12/67
22c. PHYSICIAN'S NAME (Type): KLAUS H. HUEBNER M.D.
22d. ADDRESS: NORTH EAST, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 5/15/67
23c. NAME OF CEMETERY OR CREMATORY: North East Meth. Cem.
23d. LOCATION (City, town or county) (State): North East Md.

24. FUNERAL DIRECTOR: [illegible] Paul R. Couch — ADDRESS: [illegible] North East, Md.
25a. REC'D BY REGISTRAR DATE: MAY 16 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

26572 — 06556

PLACE OF DEATH
a COUNTY: Cecil — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c LENGTH OF STAY IN b: 18 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Union Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
a STATE: Maryland — b COUNTY: Cecil
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
d STREET ADDRESS: R.D. # 4
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print) First	Middle	Last	4 DATE OF DEATH Month	Day	Year
Carl	A.	Robinson	May	29,	19 67

5 SEX	6 COLOR OR RACE	7 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8 DATE OF BIRTH	9 AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS Hours / Min
Male	White		Dec. 17, 1908	58 yrs		

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (County & State or foreign country)	12 CITIZEN OF WHAT COUNTRY?
Adm. Assistant	duPont Co.	Pennsylvania	U.S.A.

13 FATHER'S NAME	14 MOTHER'S MAIDEN NAME
Charles A. Robinson	Ida Wheeler

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16 SOC. A. SECURITY NO.	17 INFORMANT	Address
No	164-05-8667	Mrs. Janet B. Robinson, Elkton, Md.	R.D. # 4

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY-
IMMEDIATE CAUSE (a) Acute Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: 6 hr
DUE TO
Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Myocardial Infarction — 4 wks
DUE TO
(c) Coronary Artery Thrombosis — 4 wks

PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town)	(County) (State)

21 I **certify** that (I) (~~this hospital~~) attended the deceased from 4-22-, 19 67, to 5-25-, 19 67, that ( ) (we) last saw the deceased alive on 5-25- 19 67, and that death occurred at 7 A.M., from causes and on the date stated above.

22a SIGNATURE	M.D. ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS ☐	22b DATE SIGNED
Tillman D. Johnson		5-29-67

22c PHYSICIAN'S NAME (Type)	22d ADDRESS
Tillman D. Johnson	123 Singerly Ave. Elkton, Md.

23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
Cremation	June 2, 1967	Silverbrook Crematory	Wilmington, Del.

24 FUNERAL DIRECTOR	ADDRESS	25a RECD BY REGISTRAR DATE	25b REGISTRAR'S SIGNATURE
Hicks Funeral Home	Elkton, Md.		

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06573 06557

1. PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point
c. LENGTH OF STAY In This: 793 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): VA Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)
a. STATE: Penna. b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Lancaster
d. STREET ADDRESS: 104 Blossom Hill Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Oscar Middle: Otto Last: ROCHOW
4. DATE OF DEATH: Month: May Day: 23, Year: 19 67
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 4 22 1894
9. AGE (In years last birthday): 73 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired)
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (County & State or foreign country): Columbia, Pa.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Ernest G.J. Rochow (Deceased)
14. MOTHER'S MAIDEN NAME: Amelia Rellar
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes give war or dates of service): WW 1
16. SOCIAL SECURITY NO: 186-38-82-46
17. INFORMANT (Address): VA Hospital Records - Perry Point, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)
PART I. DEATH WAS CAUSED BY-
IMMEDIATE CAUSE (a): Bronchial pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 4-7 days
DUE TO
(b): Arteriosclerotic Heart Disease
DUE TO
(c): Arteriosclerosis, generalized
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Hypertensive cardio-vascular Disease
19. WAS AUTOPSY PERFORMED? YES XX NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (X) (this hospital) attended the deceased from 3-18-65, 19 to 5-23-67, 19 [illegible] and that death occurred at 2:05 pm, from causes and on the date stated above

22a. SIGNATURE: [signature] M.D. ATTENDING PHYS ☐ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 5-24-67
22c. PHYSICIAN'S NAME (Type): S. GOLDGRABEN, M.D.
22d. ADDRESS: VA Hospital - Perry Point, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: May 27, 1967
23c. NAME OF CEMETERY OR CREMATORY: Cedar Lawn Cemetery
23d. LOCATION (City or Town) (County) (State): Lancaster, Penna.

24. FUNERAL DIRECTOR: RICHARD SHEETZ FUNERAL HOME- ROHRESTOWN, Pa.
ADDRESS: Perryville, Md.
25a. FILED BY REGISTRAR (DATE): MAY 29 1967
25b. REGISTRAR'S SIGNATURE: [signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

36574 — 06558

1 PLACE OF DEATH
a COUNTY: Cecil — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point
c LENGTH OF STAY IN: 3 days
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): VA Hospital

2 USUAL RESIDENCE (Where deceased lived if institution. Residence before admission)
a STATE: DISTRICT OF COLUMBIA — b COUNTY
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d STREET ADDRESS: 7539 9th St N.W.
e IS RESIDENCE ON A FARM? YES [ ] NO [X]

3 NAME OF DECEASED (Type or print): First: Patrick — Middle: H. — Last: SEABROOKS

4 DATE OF DEATH: Month: May — Day: 14 — Year: 1967

5 SEX: Male
6 COLOR OR RACE: Negro
7 MARRIED [ ] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [X]
8 DATE OF BIRTH: 8 30 13
9 AGE (In years last birthday): 53 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life even if retired): Laborer
10b KIND OF BUSINESS OR INDUSTRY: -
11 BIRTHPLACE (County & State or foreign country): Savannaugh, Ga.
12 CITIZEN OF WHAT COUNTRY? U.S.A.

13 FATHER'S NAME: Isaac Seabrooks
14 MOTHER'S MAIDEN NAME: Blanche Travers

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes give war or dates of service): WW II
16 SOCIAL SECURITY NO: 255-03-95-21
17 INFORMANT: VA Hospital Records - Perry Point, Md. — Address

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Paralytic ileus due to — INTERVAL BETWEEN ONSET AND DEATH: 6 days
DUE TO (b): acute hemorrhagic pancreatitis — 6-8 days
DUE TO (c):
Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Severe fatty liver / Lower nephron nephrosis
19 WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20a ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d INJURY OCCURRED While at work [ ] Not While at work [ ]
20e PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21 I certify that I (this hospital) attended the deceased from 5 11 67, 19__ to 5 14 67, 19__, ~~I saw the deceased alive on~~ 19__, and that death occurred at 9:35 a.m. from causes and on the date stated above

22a SIGNATURE — M.D. ATTENDING PHYS [ ] MED DIRECTOR [ ] STAFF PHYS [X]
22b DATE SIGNED: 5-15-67
22c PHYSICIAN'S NAME (Type): S. GOLDGRABEN, M.D.
22d ADDRESS: VA Hospital - Perry Point, Md.

23a BURIAL CREMATION REMOVAL (Specify): Burial
23b DATE THEREOF: 5-18-67
23c NAME OF CEMETERY OR CREMATORY: Harmony Memorial Park
23d LOCATION (City or Town) (County) (State): Prince Georges, Md.

24 FUNERAL DIRECTOR — ADDRESS: DC
Rhines Funeral Home, 3015 12th St., NE., Wash.

25a RECD BY REGISTRAR — DATE: MAY 18 1967
25b REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1 B

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06575 — 06559

1 PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c. LENGTH OF STAY IN 1b: 35 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Union Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
d. STREET ADDRESS: 154 Hollingsworth Manor
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print) First	Middle	Last	4 DATE OF DEATH Month	Day	Year
Frank	A.	Smith	May	2,	19 67

5 SEX	6 COLOR OR RACE	7 MARRIED ☒ / NEVER MARRIED ☐ / WIDOWED ☐ / DIVORCED ☐	8 DATE OF BIRTH	9 AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS Hours	Min
Male	White		Nov. 7, 1913	53 yrs				

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12 CITIZEN OF WHAT COUNTRY?
Caretaker	Gordy Enterprizes	Virginia	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
J. Robert Smith	Mary Elizabeth Collins

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service	16. SOCIAL SECURITY NO.	17. INFORMANT (Name, relationship, and mailing address)
No	213-01-2033	154 Hollingsworth Manor Md. Mrs. Carrie Elizabeth Smith, Elkton

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b) and (c).)

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Hepatic Failure	
DUE TO (b)	Post Hepatitic Cirrhosis	4 weeks
DUE TO (c)	Chronic Alcoholism	8 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)				
20c TIME OF INJURY Month, Day, Year Hour o'm. p.m. 19	20d INJURY OCCURRED While at work ☐ Not While at work ☐	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town)	(County)	(State)

21. I **certify** that (I) (this hospital) attended the deceased from 3/4, 1967, to 5/2, 1967 that (I) (we) last saw the deceased alive on 5/1 1967, and that death occurred at 10:30 AM, from causes and on the date stated above

22a SIGNATURE	ATTENDING PHYS ☒ / MED DIRECTOR ☐ / STAFF PHYS ☐	22b DATE SIGNED
Gulmit K. Gupta M.D.		5/2, 67

22c PHYSICIAN'S NAME (Type)	22d ADDRESS
Rolando A. Najera	105 E. Main St. Elkton, Md.

23a BURIAL CREMATION REMOVAL (Specify)	23b DATE THEREOF	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
Burial	5/6/67	Bethel Cemetery	Bethel, Cecil Co. Md.

24 FUNERAL DIRECTOR (Name) ADDRESS	25a. REC'D BY REGISTRAR DATE	25b REGISTRAR'S SIGNATURE
Ralph E. Hicks Hicks Home for Funerals, Elkton, Md.	MAY 3 1967	

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

23576 — 06560

1 PLACE OF DEATH
a COUNTY: Cecil — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton
c LENGTH OF STAY IN 1b: 5 days
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Union Hospital of Cecil County

2 USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a STATE: Maryland — b COUNTY: Cecil
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Earleville
d STREET ADDRESS:
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Walter — Middle: Taney — Last:
4 DATE OF DEATH: Month: 5 — Day: 27 — Year: 19 67
5 SEX: Male
6 COLOR OR RACE: White
7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8 DATE OF BIRTH: 7/20/83
9 AGE (In years last birthday): 83 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired SALESMAN
10b KIND OF BUSINESS OR INDUSTRY: PAPER, CO.
11 BIRTHPLACE (County & State or foreign country): Pennsylvania
12 CITIZEN OF WHAT COUNTRY? U S A.

13 FATHER'S NAME: Thomas Taney
14 MOTHER'S MAIDEN NAME: Mary Wood

15 WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): Unknown N/A
16. SOCIAL SECURITY NO: 159-10-7131A
17 INFORMANT: MABEL SPENCER SPRINGFIELD, PA. Address 155 PENDELL, RD

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 4 days
DUE TO (b): Severe Arteriosclerosis — Yrs. 15
DUE TO (c):
Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Prostate Cancer-negative Septicemia.
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from May, 19 67, to May, 19 67, that (I) (we) last saw the deceased alive on May 24, 19 67, and that death occurred at [illegible] M, from causes and on the date stated above.

22a SIGNATURE: William Obenshain — M.D. — ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b DATE SIGNED: May 67
22c PHYSICIAN'S NAME (Type): Wallace Obenshain
22d ADDRESS: Cecilton, Md.

23a BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b DATE THEREOF: 6-2-67
23c. NAME OF CEMETERY OR CREMATORY: EASTLAWN
23d LOCATION (City or Town) (County) (State): SWARTHMORE PA.

24 FUNERAL DIRECTOR: Robert Tomei — ADDRESS: PIPPIN FUNERAL HOME ELKTON, MD
25a. REC'D BY REGISTRAR DATE: JUN 1 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
20 M 1/66

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

26577 — 06561

PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perry Point
c. LENGTH OF STAY IN 1b: 1 day
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): VA HOSPITAL

2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Perryville
d. STREET ADDRESS: Box 183
e. IS RESIDENCE ON A FARM: YES ☐ NO ☒

3 NAME OF DECEASED (Type or print)	First	Middle	Last	4 DATE OF DEATH	Month	Day	Year
	Charles	W.	Thomas		May	13	19 67

5 SEX	6 COLOR OR RACE	7 MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	8 DATE OF BIRTH	9 AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS: Hours / Min
Male	White	☐ / ☐ / ☐ / ☒	June 23,1915	51 yrs		

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (State or foreign country)	12 CITIZEN OF WHAT COUNTRY?
News carrier	newspaper	Perryville, Maryland	U.S.A.

13 FATHER'S NAME	14 MOTHER'S MAIDEN NAME
John W. Thomas	Dora M. Griffith

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes give war or dates of service)	16 SOCIAL SECURITY NO	17 INFORMANT	Address
Yes	WWII	216-01-7792	VA Hospital Records, Perry Point, Md.	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Acute myocardial insufficiency — INTERVAL BETWEEN ONSET AND DEATH: sudden
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH	20b DESCRIBE HOW INJURY OCCURRED. Enter nature of injury in Part I or II or Item 18			
20c. TIME OF INJURY Month, Day, Year; Hour o.m. p.m. 19	20d INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town)	(County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐ and in my opinion death resulted from Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Tillman D. Johnson M.D.
EXAMINER'S NAME (Type): Tillman D. Johnson, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, City, Town or County)

22 DATE SIGNED: 5-13-67

23a FINAL DISPOSITION (Burial, Cremation, Removal (Specify))	23b DATE THEREOF	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
Burial	May 16, 1967	Asbury Cemetery	Port Deposit, Cecil, Md.

24 FUNERAL DIRECTOR	25a RECD BY REGISTRAR	25b REGISTRAR'S SIGNATURE
Lee A. Patterson & Son, Perryville, Md.	DATE MAY 19 1967	[illegible] Judge

Lee A. Patterson & Son Perryville Md.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16578 — 05562

1 PLACE OF DEATH
a. COUNTY: Cecil — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chesapeak Elkton
c. LENGTH OF STAY IN 1b: 6 Weeks
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Elkton Hospital

2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)
a. STATE: Maryland — b. COUNTY: Cecil
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chesapeake City
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: William — Middle: J. — Last: Weaver
4 DATE OF DEATH: Month: May — Day: 14 — Year: 1967
5. SEX: Male
6 COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8 DATE OF BIRTH: May 14, 1893
9 AGE (In years last birthday): 74 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Storekeeper
10b KIND OF BUSINESS OR INDUSTRY: U.S. Eng. Dept.
11 BIRTHPLACE (County & State or foreign country): Delaware City, Delaware
12 CITIZEN OF WHAT COUNTRY?: U.S.A.

13 FATHER'S NAME: William J. Weaver
14 MOTHER'S MAIDEN NAME: Mary Bredemeier

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes give war or dates of service): WW I
16 SOCIAL SECURITY NO:
17 INFORMANT: Mrs. Mary Mullen, 204 Rodman Rd., Address: Bellefonte Wilm., Del.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CARCINOMA — INTERVAL BETWEEN ONSET AND DEATH: SEVERAL MONTHS
DUE TO (b): SECONDARY METASTASIS — SEVERAL MONTHS
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d INJURY OCCURRED While at work ☐ Not While at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from June 11, 1956, to May 14, 1967, that (I) (we) last saw the deceased alive on May 14 1967, and that death occurred at 4:40 P.M. from causes and on the date stated above.

22a SIGNATURE: Henry F. Davis M.D. — ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 5/14/67
22c PHYSICIAN'S NAME (Type): Henry F. Davis M.D.
22d ADDRESS: Chesapeake City, Md.

23a BURIAL, CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: May 17, 1967
23c NAME OF CEMETERY OR CREMATORY: Hickory Grove Cemetery
23d LOCATION (City or Town) (County) (State): New Castle County, Del.

24 FUNERAL DIRECTOR: Ralph E. Hicks — ADDRESS: Hicks Home for Funerals, Elkton, Md.
25a RECD BY REGISTRAR DATE: MAY 16 1967
25b REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

26573 — Form 4 MD Rev 6, 1964 — 06563

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH — a. COUNTY: CECIL — b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HARRINGTON — c. LENGTH OF STAY IN 1b: MARYLAND — d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): UNION Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) — a. STATE: MARYLAND — b. COUNTY — c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Warwick — d. STREET ADDRESS: Box Jc — e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: ALBERT — Middle: — Last: WOOLARD

4. DATE OF DEATH: Month: MAY — Day: 23 — Year: 19 67

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 5-23-96

9. AGE (In years last birthday): 71 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): LABORER

10b. KIND OF BUSINESS OR INDUSTRY: CONSTRUCTION

11. BIRTHPLACE (State or foreign country): MD

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: FRANK WOOLFORD

14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wars or dates of service):

16. SOCIAL SECURITY NO.

17. INFORMANT: Mary Woolard — Address: Harrington Del

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a): CEREBRAL HEMORRHAGE — INTERVAL BETWEEN ONSET AND DEATH: 2 hours

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH. NO

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) SUDDEN ONSET AT HOME

20c. TIME OF INJURY Hour a.m. 5 p.m. — Month, Day, Year: 5/23 19 67

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): HOME

20f. (City or town) WARRICKTOWN (County) (State) MD

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Henry Lewis Davis MD

EXAMINER'S NAME (Type): HENRY LEWIS DAVIS MD

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county):

DATE SIGNED: 5/23/67

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 5/27/67

22c. NAME OF CEMETERY OR CREMATORY: Dale Cemetery

22d. LOCATION (City, town, or county) (State): Middletown, Del.

23. FUNERAL DIRECTOR: Colvin Bell — ADDRESS: 909 Poplar St.

24a. REC'D BY REGISTRAR: MAY 26 1967

24b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A1SME SM 1/63

Item 20a Film 389
5/22/67 ams

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06580 — 06564

1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: CECIL
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ELKTON
c. LENGTH OF STAY IN 1b: 9 MOS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): UNION HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: CECIL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ELKTON RURAL
d. STREET ADDRESS: RD#5 DOGWOOD ROAD
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First WILLIE Middle L. Last YATES

4. DATE OF DEATH: Month MAY Day 10 Year 1967

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 12-15-28
9. AGE (In years last birthday): 38 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY: MANUF ELECTRIC MOTORS
11. BIRTHPLACE (State or foreign country): VIRGINIA
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: ADAM CHARLES
14. MOTHER'S MAIDEN NAME: OLHA BANDY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wars or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: HOSPITAL RECORDS Address: UNION HOSP ELKTON MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): FRACTURED PELVIS CRUSHED LEFT KIDNEY
DUE TO (b): RETROPERITONEAL HEMORRHAGE
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): AUTO ACCIDENT

INTERVAL BETWEEN ONSET AND DEATH: 32 HOURS

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): CROSSING HIGHWAY WHEN STRUCK AND RUN OVER BY AUTO
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): STREET
20f. (City or town) ELKTON (County) CECIL (State) MD

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Henry V. Davis M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 5/10/67
EXAMINER'S NAME (Type): HENRY V. DAVIS MD
Address (Street, city, town, or county): CHESAPEAKE CITY MD

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 5/13/67
22c. NAME OF CEMETERY OR CREMATORY: YATES Cemetery
22d. LOCATION (City, town, or county) (State): GRUNDY, VA.

23. FUNERAL DIRECTOR: Hicks Home for Funerals, Inc. ADDRESS: Joseph E. Hicks, Elkton, Md.
24a. REC'D BY REGISTRAR DATE: MAY 15 1967
24b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15ME
5M 1/63

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06581 06565

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH a. COUNTY: Cecil — MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton c. LENGTH OF STAY IN 1b:	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE: Maryland — b. COUNTY: Cecil c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Elkton R.D. # 3 d. STREET ADDRESS: Blue Ball e. IS RESIDENCE ON A FARM? YES ☐ NO ☒
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Union Hospital	

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
Horace	T.	Yerkes	May	3,	1967

5. SEX	6. COLOR OR RACE	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White		Sept. 23, 1893	73 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Fabricator	Fibre Co.	Maryland	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Clinton J. Yerkes	Jennie Taylor

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Blue Ball Address R.D # 3
No	221-18-8733	Mrs. Esther M. Yerkes, Elkton, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Metastatic Malignant Lymphoma	
DUE TO (b)	Cancer of Lung	1 year.
DUE TO (c)	Cancer of Lung Cap.	1 1/2 yr.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Senile Dementia Coronary — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)

21. I certify that (I) (this hospital) attended the deceased from 4/22, 1967, to 5/3, 1967, that (I) (we) last saw the deceased alive on 5/3 1967, and that death occurred at 4:22 M, from causes and on the date stated above.

22a. SIGNATURE	M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐	22b. DATE SIGNED
Peter Stavrakis		5/5/67

22c. PHYSICIAN'S NAME (Type)	22d. ADDRESS
Peter Stavrakis	154 W. Main St. Elkton, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	5/7/67	Rose Bank Cemetery	Calvert, Cecil Co. Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Hicks Home for Funerals	Elkton, Md.	MAY 8 1967	J. Charles Judge